IN THE UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Jane Doe #1; Jane Doe #2; Norlan Flores, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

Chad Wolf, Acting Secretary of Homeland Security; Mark A. Morgan, Acting Commissioner, U.S. Customs and Border Protection; Carla L. Provost, Chief of United States Border Patrol, in her official capacity; Roy D. Villareal, Chief Patrol Agent-Tucson Sector, in his official capacity,

Defendants.

CV-15-250-TUC-DCB

January 17, 2020
9:09 a.m.
Tucson, Arizona

REPORTER'S OFFICIAL TRANSCRIPT OF PROCEEDINGS

BENCH TRIAL

DAY FIVE

(PART ONE OF TWO)

BEFORE THE HONORABLE DAVID C. BURY
UNITED STATES DISTRICT JUDGE

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P R O C E E D I N G S

THE COURT: All right. Back on the record, and we're ready for our next witness, I assume, to be presented by the Government.

MR. CELONE: Defendants call Dr. David A. Tarantino, Your Honor.

THE CLERK: If you'd step into the witness box, please.

DAVID A. TARANTINO, WITNESS, SWORN

THE CLERK: Thank you. Please be seated.

If you'd state your full name and spell your last name for the record.

THE WITNESS: David Tarantino, T-a-r-a-n-t-i-n-o.

THE COURT: Good morning, sir.

THE WITNESS: Sir.

THE COURT: Go ahead, counsel.

DIRECT EXAMINATION

BY MR. CELONE:

Q. Good morning, Dr. Tarantino. What is your title?

A. I am the CBP Customs and Border Protection Senior Medical Advisor.

Q. And how long have you been in that role?

A. About two years or a little over two years.

Q. And what does that role entail?

A. I provide medical direction and oversight for CBP medical

efforts.

Q. And that's across all of Customs and Border Protection?

A. Yes, and geographically as well as across all lines of operation and across all sort of mission space.

Q. And prior to that, what was your medical background?

A. Well, how far back do you want me to go?

Q. Let's start with your education and kind of advance from there.

A. I was premed at Stanford University, and then that led me to Georgetown University Medical School, and I got my M.D. from there. And that was on a Navy scholarship, so I joined the Navy after that, and I did additional internship training with the Navy. I became a Navy flight surgeon, so I did a lot of operational medicine, aerospace medicine, preventive medicine, occupational health, and a lot of operational medicine with the military.

Then I also did a residency in family medicine, so I became board certified in family medicine, which is a specialty, a clinical specialty, covering pediatrics, OB/GYN, and adult care, and -- which has actually come in very handy for dealing with the issues of today, because that's our population in custody, and that's the one specialty that is sort of clinically trained and certified to cover that whole spectrum.

I also then did a lot more assignments with the military,

a lot of overseas operational medical experience on six continents, including a lot of humanitarian assistance and disaster response work. I then did a fair amount of time in the Pentagon working on health systems and health programs and health policy, helped setting up Department of Defense and U.S. Navy and Marine Corps health systems and health programs.

I spent a year in Iraq where I helped set up the Iraqi health system after -- after the 2003 military intervention, and then I spent a fair amount of time in Afghanistan also, helping them set up their health system.

And I became the Medical Director of the Marine Corps, or I was Director of Medical Programs for the Marine Corps, so for the entire Marine Corps I was responsible for direction and oversight of their medical programs in garrison at home but also overseas in Afghanistan and Iraq.

And then I spent -- my last assignment was at the Uniformed Services University, so I was a professor there where I taught medical systems, medical programs, unit humanitarian medicine, operational medicine, a whole array of subject matter.

I retired and I ran a nonprofit, the Yellow Ribbon Fund, for a year, and then I spent a year with International Medical Corps, which is a global humanitarian organization similar to Doctors Without Borders. I did a lot of global relief work, humanitarian work, refugee medicine, and then I ended up at

DHS/CBP.

Q. Great. And in your role in the military, working in battalion aid stations and things, what type of involvement did you have with medical intake or medical assessments?

A. I've had significant involvement with that in a number of venues over my career, be it military, be it disaster response, be it humanitarian settings, so I have a lot of experience in that area.

Q. And specifically with medical screening or assessments, what type of level of involvement have you had?

A. Well, I've designed the systems, the programs, I've provided the medical direction, the oversight, I've provided the quality assurance and the review of a number of such efforts, in a number of settings.

Q. And do you believe that's prepared you well for your current role in assessing the medical care needed in Border Patrol stations?

A. Yes. I feel like my experience and expertise was sort of, by happenstance, the totality of it was exactly what I needed for this role that I have in Border Patrol and Customs and Border Protection because it combines operational medicine, humanitarian medicine, family medicine, medical systems, medical programs, medical planning, medical quality management, all of which I have extensive experience and expertise in.

Q. And in the two years that you've been in your current role as Senior Medical Advisor, how has the medical care improved, would you say, in Border Patrol Stations?

A. There has been a continuous significant ongoing expansion and enhancement of the CBP medical support capabilities in scope and scale, and you know, there is -- I could -- I could go on for a long time about that. You know, there is a lot of different branches of that, and that's -- that's beyond even the detainee health care arena, which I know we're interested in today, because Customs and Border Protection has a number of lines of effort, many of which interact with this. For example our EMT program, we've been growing and enhancing that, which then helps us on the detainee health mission.

But specific to the detainee health mission, there has been a significant expansion and enhancement in scope and scale of that. The largest, most visible sign of that is the medical support contract that we have in place, which we started on my watch, and with my -- with my involvement, we started -- well, let me back up.

That contract started back around 2014-2015, and for -- and that was -- that was built out of a prior crisis that was focused in RGV back at that time. Out of that came this construct to use this contract medical team approach, but that had been limited to RGV, to a few locations in RGV, for a number of years because the crisis had kind of abated, and we

were back to sort of a steady-state operations.

But a year and a half ago, even more than a year and a half ago, we started to see -- I started to recognize the benefit of that construct broader than RGV, but also we started to see some early indications of some uptick in traffic and hearing talk of seeing some signs of caravan movement, other things, so we started to expand that contract well before the caravans. Well before the most recent crisis we started to expand that contract to some other priority locations.

As the crisis began to really pick up pace and as we were able to identify additional resources, we started to dramatically accelerate the expansion of that contract such that, you know, a year ago that contract was in maybe six, seven facilities and maybe had a few dozen medical professionals. Now we're in over 45 facilities, and we have over 700 medical personnel on contract.

In any given day there's over 300 who are actively providing medical support along the southwest border, and that goes from southeast Texas all the way to southwest California, and to include -- to include Tucson Sector as well.

So that's one kind of vivid example, but there's been other significant enhancements in terms of our -- of our initial assessment processes, our public health infectious disease, our flu control measures. I could go on and on, but

that's sort of a vivid example of the expansion enhancement that we've been making.

MR. CELONE: Ms. Kershaw, could you pull up Joint Exhibit 868, please.

BY MR. CELONE:

Q. And Dr. Tarantino, is this the -- have you seen this document before?

A. Yes.

Q. And is this the statement of work that provides the guidance for the medical contractors?

A. Yes. Now, I can't -- I can't say definitively that this is the most current one, but this is what I have seen, and I'm very familiar with it. We do make modifications to it with task orders and other things, so I can't speak to its 100 percent currency, but this is -- this is what I've seen and what I'm familiar with.

MR. CELONE: Your Honor, move to have Joint Exhibit 868 admitted to the record.

MS. BALASSONE: No objection.

THE COURT: It's admitted.

MR. CELONE: Thank you, Ms. Kershaw.

BY MR. CELONE:

Q. And Dr. Tarantino, what is the name of the medical contractor who's providing this care?

A. It's Loyal Source Government Services.

Q. And so you said they were originally in a -- or now they're in -- they were in six to seven facilities, now up to 45 facilities. What is the -- what type of criteria or factors go into deciding where the medical contractors will be located and providing care?

A. Right. We use an operational risk management methodology whereby we're constantly evaluating volume, demographics, crowding, length of time in custody, access to care, remoteness, a number of other variables that allows us to identify the priorities, the facilities that are most -- represent a priority for the enhanced medical support, the placement of medical support teams.

We're still in a growth and an expansionary phase, so we have not reached a steady state level-off area, so we're still identifying additional priority locations, and we use that methodology. That could even lead us to shift resources from time to time, and it's still informing our continued expansion as well.

So it's a -- it's a -- it's a very thoughtful and collaborative operational risk management process that involves the stations, the sectors, the headquarters, my input, and we're able to identify priority locations through such a methodology.

Q. Okay. And what are the operational benefits of having medical contractors in place?

A. Well, certainly there's a number of reasons why we have medical support in place. One of them, a primary driver, is that it enhances and supports our operations. It allows us to conduct operations more effectively and efficiently in these priority locations.

One example, if we are able to identify and handle medical issues on-site. These would be basic medical issues, basic care for some simple, uncomplicated problems and/or even to just identify a potential medical issue and determine the level of severity of it, the triage.

And if we're able to provide treatment or medication, adjudication, provide medication on site, that saves trips to the hospital, and trips to the hospital are very operationally impactful for us because we typically send two agents as hospital watch escort, and they're there for the duration of the hospital visit. That takes our agents out of processing, and that takes our agents out of the field, takes them off the line. So of course we're willing to do it and will do it, but if we can handle more of that internally, without sacrificing quality, then that's a win-win for the patient as well as for the operators and as well for our mission.

So that's one example of the operational benefit, but also, you know, our operations are designed around a law enforcement mission but also providing for those in our custody, and to include medical care. So if we're able to

provide better, quicker access to medical care to persons in our custody, then that's enhancing our operational mission.

And thirdly I would say that it also benefits us in terms of taking care of our own people, because if we're able to address medical issues on-site, prevent the spread of infectious disease, also take some of that burden off of the agents or officers, then that's a win as well for us.

Q. And what types of medical issues do the medical contractors address on-site?

A. Well, they're a big part of the initial assessment process, which I can -- I imagine I'll get asked about, and I could go into more detail on that, but they're a big part of the initial assessment process, triage, if you will. They can also adjudicate medication issues, identify if medication needs to be replaced or reordered or adjusted.

They can and handle basic nonemergency, non-life-threatening, noncomplex type issues, common colds, you know, cuts, scrapes, coughs, nausea, vomiting, scabies, lice, anything that is -- and our system -- I should say our system is still designed to really revolve around the local health system.

We have a low threshold for referral to the emergency room or a hospital to get definitive diagnosis and treatment, just like the population of Arizona or wherever we are. We still try to apply and maintain local standards of care, and

we will refer to or defer to the local health system, but in appropriate circumstances, consistent with the training and certification of our providers, we're able to handle some medical issues on-site.

And that helps us, it helps the patient, and it helps our -- it helps our operators, it helps the patient, and also helps our people to do that.

Q. And what is the medical team construct with the medical contractors? What type of personnel do they have on-site?

A. A typical team would be an advanced practice provider, which is a physician assistant or a nurse practitioner, and then they would have two technicians, might be an EMT, might be a medical assistant, but a medical -- a medical technician, a medical assistant.

Sometimes, depending on the volume, and also we're still in the growth phase, to some extent, in terms of hiring and such, sometimes certain shifts there might be one technician, one assistant. And then they work in shifts, so they provide 24/7 coverage.

And they also have -- we have added additional layers above that, where we have physician supervisors who are doctors, M.D.s, who provide medical direction, oversight, consultation, medical quality management, coordination and outreach with the mid-level, with the advanced practice providers.

We've also brought on pediatric advisors who can provide pediatric-specific consultation and training and protocol, advising, and referral coordination, and quality -- quality management as well on a pediatric-specific basis.

Q. What's the scope of supervision that the physician supervisors will provide?

A. Well, they're part of our medical quality management process. We have a medical quality management process that is -- that parallels the standard processes that you would see in analogous medical settings. And so we have the initial licensing/credentialing/certification process. Then we have the ongoing -- the focused and ongoing professional practice evaluation whereby our providers have their charts reviewed on a regular basis by the physician supervisors to look at their clinical decision-making and clinical practice, their acumen, and we will use that process to look for areas of improvement or areas of remediation.

We also have sentinel event reviews where, if there is an adverse event or unusual events, the physician supervisors and our medical quality management team can take more of a deep dive into that, look at issues related to that.

So we do have a robust medical quality management program. Our physician supervisors are a key part of that to -- to provide that level of review and oversight for the advanced practice providers. I'm involved in those processes

as well.

We have also brought on patient safety risk managers, patient safety quality managers, at -- across our, you know, sort of sector level across the southwest border, and we have a national patient safety quality manager who coordinates our medical quality management efforts at large.

So we've been building in additional layers, you know, sort of pyramidal additional layers of professional medical support and oversight and quality management as this process has grown. You know, it started a handful of people in a few locations a little over a year ago, and now it's blossomed significantly, so we've been adding in the additional appropriate layers and levels of medical direction, oversight, coordination, and quality management.

Q. And specific to the Tucson Sector, where is the Loyal Source -- or is Loyal Source Government Services providing medical contract care to Tucson Sector?

A. Yes, they are at the TCC. In fact, I had a chance to revisit yesterday and have another look at that. I've been out to Tucson Sector many times, and I've been here earlier as Loyal Source was standing up, and now they've also recently established at Nogales, at the Nogales Station.

Q. And how -- what was the decision-making process for implementing LSGS -- I'm going to call Loyal Source Government Services by the acronym LSGS. What was the process for

deciding where to install LSGS into Tucson Sector?
A. We used that same operational risk management methodology, and so we worked with the sector to identify within Tucson Sector what would be their first priority, again, based on volume, demographics, flow, access to medical care, concentration of medical issues. And between the sector and headquarters and myself, there was a pretty easy consensus, I think, that TCC was the place to start, was the top priority.

Now, my job -- you know, Tucson Sector's job is to identify their priorities within Tucson Sector. One of my jobs and Headquarters' job is to cross-match that across the southwest border, and so that's why some might ask, well, why -- why was a team set up somewhere else outside of Tucson Sector before TCC? Same -- the same equations, the same methodology is used there. It's used across sectors, but it's also used within sectors.

So that's why TCC was identified as the first location within Tucson Sector, and that same methodology led to the conclusion that Nogales would be the second, the next priority location within Tucson Sector.

Q. And let's start with TCC. So what is it that's unique about TCC, or is there something unique about TCC, that led to that conclusion of installing LSGS there first?

A. Well, I think people who are familiar with this case or

this sector probably understand that TCC played sort of a hub-and-spoke role within the sector and that it is the central processing center, essentially, for all of Tucson Sector. So most if not vast majority if not all of the people who are brought into CBP custody will eventually make their way through Tucson Sector. It's sort of a collection and then onward movement point.

And so that in and of itself was a key factor in being able to do the greatest good for the greatest number and be at the -- be at the point that is the most sort of critical -- critical central point for Tucson Sector operations in terms of processing and short-term holding.

Q. And as far as Nogales -- well, let me back up for a second.

When did LSGS first move into -- where they stood up in the Tucson Coordination Center?

A. I can't remember that date. I remember being involved in those discussions. I remember being there shortly thereafter. I can't remember that date. You know, obviously, I know -- I have documents, and I have my own chart, and we have tracking of every single site with every single date of when it was stood up, so I just -- I didn't bring that level of detail with me, so I can't recall specifically. I don't want to venture a date and have it be wrong.

But I was definitely involved in the process of it, and I

was there shortly before, I was there when Loyal Source wasn't there, in fact, and I was there shortly after.

Q. Would you say it was sometime last summer?

A. Yes.

Q. Okay. And you said that Nogales was the next phase of the LSGS expansion. When was LSGS stood up in Nogales Station?

A. Yeah, and again, to have the exact date, I'm not sure. That was sometime in mid-December, and --

Q. Of 2019?

A. Yes.

Q. And similar to TCC, what were the unique criteria or were there unique criteria in Nogales that led to the decision to expand LSGS to Nogales Station?

A. Again, that would have been using our operational risk management methodology, looking at volume, flow, demographics, remoteness, access to care, time in custody, level of -- level of census, if you will, and throughput, and based on what I've -- I visited Nogales, and speaking to the Tucson Sector leadership and headquarters leadership, I think there was a consensus -- a very general consensus that Nogales would and should be the next priority for Tucson Sector based on obviously its location and proximity to some transit points and historical -- historical flow patterns and a number of other -- number of other factors.

Q. And prior to LSGS's expansion to Tucson Sector, were there physicians or any other medical providers in place over the past year?

A. I'm sorry. Could you repeat that.

Q. So prior to LSGS's expansion into Tucson Sector, were there other medical providers on-site in Tucson Sector or at TCC providing medical care?

A. We did have a period of time where we had Coast Guard and Public Health Service teams providing sort of short-term surge support for us as we were ramping up the Loyal Source contract. That isn't as easy as you might think because it involves a lot of background investigation. We need to make sure that anyone who's going to be coming into our facilities interfacing with people in our custody have gone through the requisite background checks, and of course we have to verify their credentials, their licensing, their certification, so that takes a little bit of time to ramp up such an undertaking across such a broad -- a broad scope and scale.

So during that period, we didn't want to leave some of the priority locations without the additional medical support, so we worked with Coast Guard and Public Health Service to bring some teams in on a temporary basis.

Q. And now that LSGS is in place, there's no longer that need for Coast Guard or Public Health Service? Is that --

A. Correct.

Q. And your level of involvement with LSGS, is it -- do you oversee the contract, so to speak?
A. I am not the contracting officer for the Corps, but I am involved in the day-to-day coordination and oversight and guidance for the contract, particularly on the medical side of things. There's certainly some -- a lot of non-medical aspects to contract management, obviously, that I don't have the lead for, but I'm involved in those discussions, and it's a very collaborative process at the headquarters level. But I'm very immersed in it and very, very involved in it.
Q. And do you work with the -- with LSGS to identify different areas for improvement, in collaboration with the sectors?
A. Yes. I have an open line of communication to the Loyal Source leadership. They're very responsive to evolving circumstances. As you can imagine, there's no way you could write a contract five years ago or even a statement of work or a modification a year ago and have it be a hundred percent applicable to what we're seeing on a regular basis.

So there is adaptability, there is the ability to adjust, and that can be -- within a certain band that can be done based on just discussions. If we get outside of that, then we can do a task order modification to add some more processes and/or expansions of the contracted services.

So it is a flexible vehicle, and the contractor has been

very flexible and responsive.

Q. Great. Now I want to kind of talk about the general process of medical compare or the continuum of care that's provided in Tucson Sector.

Based on your understanding, when somebody is apprehended in the field, what is their -- what type of initial medical assessment or screening, so to speak, will they receive --

A. All right.

Q. -- before they arrive at the station?

A. So sometimes I describe our medical assessment process as a three-phase process which is part of a larger multiphase process, but the medical assessment process has three phases for descriptive purposes.

Phase 1 is agent observation and patient -- sorry -- patient or person self-reporting, and that can -- that can happen out in the middle of nowhere, out in a remote desert outpost, where an agent is going to use their training and their experience to look and -- look, listen, feel, hear, observe anyone they're bringing into custody for any signs or symptoms or even history of any significant illness that might be urgent, emergent, life-threatening.

And of course they're going to listen to self-reporting. They're going to ask, are you sick, ill, something wrong? And so even that far out, there can be that level of interaction, and if there is something identified that appears to be

urgent, emergent, life-threatening they can engage one of our EMTs, if they happen to be on-site or nearby, or they can transport to the local hospital, or they can activate EMS, which is a fairly regular occurrence, even calling in a Life Flight, which happens on a fairly regular basis, or calling in one of our own aircraft to do an extraction or a rescue or a transport.

So that can happen anywhere, at any time, and that's -- sorry again -- that's phase 1, which is agent observation, and then patient self-reporting. And that's to your -- that's to your question about the initial interaction, I think.

Q. When you said our own aircraft or EMS, is that -- were you referring to the BORSTAR unit?

A. Yes, could be BORSTAR and it could be AMO, our Air and Marine Operations. They have -- they have a branch here, and they have helicopters at their disposal. That's another branch of CBP who works with BORSTAR, works with Border Patrol.

Q. And then so when -- assuming somebody does not have an emergent issue that requires them to go to the hospital, so on the assumption an individual's brought to the station, what is your -- your understanding of what type of medical observation or screening occurs upon arrival to the station?

We'll start --

A. That would be what I could characterize as phase 2.

Obviously phase 1 still applies, but phase 2 would be a health intake interview, which I know -- I think that's been -- I think maybe, sir, you may have been involved in putting that in place for Tucson many years ago, which was --

MR. CELONE: And let's -- Ms. Kershaw, would you mind bringing up Exhibit 206, please.

BY MR. CELONE:

Q. And Dr. Tarantino, is this what you were referring to, the initial medical screening form that was --

A. Yes.

Q. -- in place?

A. This is -- to my understanding and in my experience, this is a form that had been used in Tucson for a number of years, in Tucson Sector for a number of years.

MR. CELONE: And I'm going to, Your Honor, move for Joint Exhibit 206 to be admitted into the record.

MS. BALASSONE: No objection.

THE COURT: It's admitted.

MR. CELONE: And Ms. Kershaw, could you bring up Joint Exhibit 881, please.

BY MR. CELONE:

Q. And Dr. Tarantino, are you familiar with this form?

A. Yes. This is the CBP Form 2500. This is the now standardized CBP-wide health interview questionnaire, and sometimes we call it the health intake interview. And this

was meant to standardize -- there was not only the previous Tucson form. Other sectors had other forms. Other parts of CBP had other forms.

This was an effort to standardized that but also to incorporate some lessons learned in best practices over the years. This form was specifically designed to in no way step back from the Tucson form, but there is some incremental improvements in some of the wording, some additional -- additional parameters that are featured in here, also sort of the organizational structure of it.

But in no way is it -- does it decrement in any way what had been being done in Tucson Sector, but this was a significant effort by us to standardize this across CBP and make it consistent with Tucson practices but also our electronic systems and also to make sure that this had been reviewed broadly by a number of experts and internal and external stakeholders, so this was developed through a very collaborative process that actually took months.

And so this is -- that's what this is, and that's how we got to this today. So this would be phase 2. You know, to continue my loose phase description, this would be phase 2, which would be the health intake interview.

Q. And to your understanding, this health interview questionnaire is being asked of all detainees in the Tucson Sector upon arrival to a station?

A. Yes, that's what -- that's what I've heard as the guidance put out by Tucson Sector, that's what I've seen in practice, and that is my understanding of what is happening in Tucson Sector.

Q. And you said that you've arrived at that based on observation in the stations?

A. Yes.

MR. CELONE: Your Honor, move to have Joint Exhibit 881 into the record.

MS. BALASSONE: I think it's already admitted.

MR. CELONE: Excuse me. Thank you.

THE COURT: All right.

BY MR. CELONE:

Q. And so Dr. Tarantino, what occurs if somebody answers yes to any of these 13 questions?

A. Well, the -- if someone answers yes to one of the questions that, you know, identifies, like, on this form, that identifies a medical issue, or it doesn't even have to be a yes to one of these questions, it could be additional observations, or down below we actually added in additional discretion, again, for the agent or officer to just say, hey, something doesn't look right, something doesn't sound right, this person's saying everything is fine, but it doesn't look that way to me, that would trigger a medical assessment, in which you see at the bottom of the page, "Was the alien

referred for medical assessment? Yes or no."

Q. And what happens if -- when somebody is referred to -- referred for a medical assessment?

A. That would -- that would be what I would describe as phase 3 of our assessment process. They would get a medical assessment by medical personnel, and that could be by referral to the local hospital, to the emergency room or the hospital, if our Loyal Source is not on-site or available, or it could be by Loyal Source -- the assessment could be done by our Loyal Source personnel on-site.

Q. Great.

MR. CELONE: And Ms. Kershaw, could you bring up Joint Exhibit 884, please.

BY MR. CELONE:

Q. Dr. Tarantino, have you -- are you familiar with this exhibit?

A. Yes.

Q. Is this the medical assessment form that would be used in that phase 3 that you were describing?

A. Yes. Now, I can't speak to -- a hundred percent to a version control issue. I think that there -- there may be another version of this that's not specific to juvenile. But this form I helped develop. I'm very familiar with it. This is -- this would be the medical assessment form that would be used as that phase 3 process to conduct a medical assessment.

Q. And this medical assessment would be conducted by a medical practitioner; is that correct?
A. Yes.
Q. And to your understanding at the TCC, who is receiving or which individuals are receiving medical assessments?
A. My understanding of the practice at the TCC and what I observed in fact yesterday is that all juveniles will receive a medical assessment, and any person who has been observed or reported or had a positive -- reported to have a medical issue, a medication issue, or a positive finding on the health interview would get a medical assessment.

And so to clarify that, that means that juveniles would be getting a medical assessment even if phase 1 and phase 2 were completely normal or completely negative. We would have a medical assessment conducted on the juveniles as an extra precaution, if you will.

Q. And that medical assessment is upon arrival to the TCC?
A. Maybe not upon immediate arrival. The health interview is conducted immediately in the sally port before they even come into the facility, and that's to identify public health infectious disease issues and address them up-front. The medical assessment will follow shortly thereafter.

They may go through some -- depending on the acuity of the issue, if it looks urgent or questionable, if it's more routine, they may go through some additional processing,

and/or the provider may have a backlog, but they'll get the medical assessments expeditiously.

Q. We talked about how the health interview questionnaire is asked upon all arrivals to the station. What happens hypothetically if somebody is asked the health interview questions upon arrival to the Ajo Station and then they're brought to the TCC subsequently? Does that health interview questionnaire -- is that asked a second time?

A. I think that probably we'd say it wouldn't necessarily be required to by our policy, but in our practice it is, and we saw -- I saw it yesterday. And in fact, it's even being done essentially twice in the sally port. It's being done by medical as well as by the agents, and they collaborate and work collaboratively on this. So the agents will be asking these questions, but also our medical personnel will be asking it at the TCC.

So there is a high likelihood that persons in custody will be getting health interviews multiple times, and from our perspective, you know, that's fine. And so they generally are, will get it at a -- at the outlying station, but they will also get it at the TCC.

MR. CELONE: Ms. Kershaw, could you pull up Joint Exhibit 882, please.

BY MR. CELONE:

Q. Dr. Tarantino, are you -- have you seen this document

before?
A. Yes.
Q. What is it or how would you describe it?
A. As entitled, "Patient Encounter Note," this would document a medical encounter, which this is part of our -- of the continuum of care that we have. This would follow phase 3, essentially. This would be, if you would, a phase 4 whereby this would be a medical encounter if someone was actually identified as having an illness, an injury, an issue that needs to be addressed by a provider, and that would be documented here.

And that could be upon initial entry, or it could be 24 hours later something manifests. A person is in -- is in holding and they develop some nausea or vomiting and they need to be looked at, that would be documented on this encounter note.

MR. CELONE: Just, excuse me, one housekeeping item, Your Honor. We wanted to move Joint Exhibit 884 into the record, but I believe it already -- it may have already been entered.

Is that -- has it already been?

MS. BALASSONE: You mean 884?

MR. CELONE: Yes, the juvenile --

MS. BALASSONE: I believe it's already been admitted.

MR. CELONE: I thought so as well.

Move to have Joint Exhibit 882 admitted to the record.

MS. BALASSONE: No objection.

THE COURT: Admitted.

BY MR. CELONE:

Q. And so Dr. Tarantino, the phase 4, so to speak, or the patient encounter note, how would LSGS kind of arrive to the encounter stage? What would trigger the evolution from phase 4 to phase -- or phase 3 to phase 4?

A. That would be -- well, an easy way is, if you want to go back to that, if you go back to the assessment form, I can show you.

MR. CELONE: Ms. Kershaw do you mind pulling up or having simultaneously on the screen Joint Exhibit 884 and 882.

A. So if you look at 884, down at the bottom, "Assessment Disposition," you can see there's three general assessments. One is, there's no -- there's no -- despite what was said before, you know, despite someone having a question about a medical issue, we have now had a medical provider look, and they've decided that there is nothing of any significance going on at this point in time, so they can continue processing.

Or they might say, hey, this is a really emergent, complex issue. We can't handle it here. They have to go to

the emergency room. Or they could say, this person does have a medical issue. We can handle it here. We're going to initiate a medical encounter. And that will be done on-site if available. Otherwise, even for a routine -- quote/unquote routine medical encounter, that would go to the emergency room if it couldn't be done on-site. And so if it does lead to a medical encounter, that would generate this patient encounter note.

MR. CELONE: And Ms. Kershaw, could you pull up Joint Exhibit 882, page 2, please. The second page. Yes, thank you.

BY MR. CELONE:

Q. So for the right-hand screen, how does -- I mean, these types of questions are a follow-on or all part of the encounter; is that correct?

A. Yes. This is the back side of the form. This is -- this is all part of the patient encounter.

MR. CELONE: Ms. Kershaw, could you bring up Joint Exhibit 883, please.

BY MR. CELONE:

Q. And Dr. Tarantino, are you familiar with this document?

A. Yes.

Q. How would you describe this document's purpose or role in the different phases of the continuum of care?

A. Yeah, this would be a medical continuation note. If

during an encounter it was identified that a person had a medical issue that was going to require some continuation or additional monitoring such as you see here, temperature checks, blood pressure checks, glucose checks, medication administration, that would be determined during the assessment and encounter period, and then it would be implemented and documented on this form.

Q. In all of these LSGS forms that we've been looking at, these are -- these encounters and assessments are all performed by the medical providers; is that correct?

A. Yes. Now, a temperature check, if someone needs a repeat temperature check, that might be performed by one of the technicians, but it would be under the direct supervision of the provider, who's on-site 24/7.

Q. Okay. Great.

MR. CELONE: Your Honor, move to have Joint Exhibit 883 admitted into the record.

MS. BALASSONE: No objection.

THE COURT: It's admitted.

MR. CELONE: Ms. Kershaw, could you bring up Joint Exhibit 881 again, please.

BY MR. CELONE:

Q. So Dr. Tarantino, I wanted to step back to the health interview questionnaire that's performed, as you testified, upon all individuals upon their arrival to Tucson Sector

Station.

Which -- who -- do Border Patrol agents, are they the ones performing this health interview questionnaire?

A. It can be performed by Border Patrol agents or by medical personnel.

Q. And then is this -- where is this questionnaire documented?

A. This is documented in the e3 system.

Q. And are there any instructions for Border Patrol agents to ask these questions, or are there instructions complemented -- or contemplated, excuse me?

A. Well, in the Tucson Sector, this is very similar to what they've been doing for years, so there hasn't seemed to be any significant learning curve there. We have developed additional -- or have been developing, I should say -- additional instructions for this form. It goes into a little bit more detail, which might become a training module, but we're still getting feedback from the users on this in terms of what their questions are about it, what might be confusing, what might -- what they might need further training or explanation about.

So we're still interacting with the field and with our agents and collecting feedback on this, which could end up in forming some additional instructions or some additional training modules or something like that.

Q. Great.

MR. CELONE: Ms. Kershaw, could you bring up Joint Exhibit 915, please, which I believe has already been admitted to the record.

BY MR. CELONE:

Q. Dr. Tarantino, are you familiar with this document?

A. Yes.

Q. How would you describe this document or its purpose?

A. This document was an effort to sort of capture/codify where we are at this point in a continuously evolving and expanding process. This was an effort to document and clarify some guidance about where we are and where we're going. It's kind of a snapshot in time of a much broader system and a much broader level of effort in scope and scale, but it does capture some key and important points and milestones.

But -- some people have read into it as the be-all/end all and only -- only-and-this-is-it sort of document. That is not the case. In many ways we have already exceeded this document, including in Tucson Sector, and we continue to evolve and enhance our practices.

And this document will be further informed as in the document by the more detailed implementation plans that will be developed that will go into some additional detail.

MR. CELONE: Ms. Kershaw, can you pull up page, excuse me, page 4 of Joint Exhibit 915.

BY MR. CELONE:

Q. So Dr. Tarantino, under subsection 7 entitled, "Procedures," subsections 7.2, 7.3, 7.4 outline a number of different phases, including phase 1 -- first phase, second phase, third phase.

Could you briefly describe how these phases interact or intersect with the various phases that you had identified earlier in the Tucson Sector?

A. Right, and this was what I was describing before, that CBP-wide and in Tucson Sector we use this three-phase approach for the initial assessment. We have -- as I said, we have additional phases beyond that, but for the initial assessment period, if you will, we have the three phases, which is, first of all, it's agent/officer observation, and then it's also persons' or subjects' individual self-referral or self-reporting of issues.

So that's phase 1. That can happen out in the middle of the desert, on first contact, or anywhere throughout the process. Second phase would be at a station where the health interview, the new standard CBP 2500, would be conducted. You'll note this -- this document says that will be done on all individuals under the age of 18 but also notes it at a minimum, and that gives sectors, including Tucson Sector, leeway to obviously conduct this on all persons, which is the guidance within Tucson Sector.

In some ways this -- and people will ask, well, why doesn't it say all individuals? In some ways that's the difficulty in writing a document that is CBP-wide, because we have -- if we make it a set policy in here, it has to apply everywhere all the time, and that can be very difficult in some very remote locations or locations that don't even exist yet because they've never been a transit route.

And so it was -- it was difficult to draft a document that went as far as we want but also didn't commit us to something that we might not be able to meet on day one of when it was -- when it was put out. That's why the language has "at a minimum" in many areas, because as I said before, in many cases, we expect to and already are exceeding these kind of de minimis, or I won't say de minimis, but minimum -- minimum standards, if you will.

Q. And so in Tucson, everyone -- to your understanding, everyone is receiving that health interview questionnaire?

A. Yes.

Q. Not just individual -- not just juveniles?

A. And I would just reclassify that, in my opinion, that is not at odds with what this says here.

Q. Because of the "at a minimum" language?

A. Yes.

Q. And provides that threshold that sectors can rise or go above?

A. Yes. And then the third phase, as I mentioned before, will be the medical assessment phase, and you've seen that described in more detail. You saw the form. Again, at a minimum, all tender age children, and then I can't see the rest, but I know it says anyone who had a positive finding on the observation or the health interview or anyone with a medical issue identified in one way or other.

So as I said, here in Tucson Sector, we're already exceeding that standard, that "at a minimum" level, because our practice here in Tucson Sector is to do the medical assessment on all juveniles, regardless of whether they had a positive health interview or not. And so that's another example where we've been able to put the resources in place and also have -- have -- the circumstances are amenable to expanding that to all juveniles.

Q. And in addition to Tucson Sector exceeding the phase 2 requirement here regarding the health interview, are there other additional phases that are being used in Tucson Sector that exceed these three phases?

A. Well, you said in addition to doing all persons versus just juveniles on the health interview. That's one area. The other area I mentioned is that, in Tucson Sector, on the medical assessment, they're doing all juveniles, not just all tender age children.

And then this document does not speak specifically to the

level of care and support that Loyal Source has set up at Tucson, at the TCC and now Nogales, so that -- that is anticipated in this document, but it's not required, and that will come in the implementation plans and other areas, but TCC and Nogales are certainly exceeding the expectations of this document by having all the medical providers on sight 24/7 and all the levels of capability that they're able to provide in that regard.

Q. And so you had identified up to phase 5 of different -- on the continuum of medical care. Are there any phases beyond phase 5, which I believe you had characterized as the continuation --

A. Yeah, so just to put it back into perspective, phase 1 would be agent observation and self-reporting. Phase 2 would be the health interview. Phase 3 would be the medical assessment. Phase 4 would be a medical encounter, which would be an actual clinical encounter for a specific issue. Phase 5, if you will, could be -- you know, again, this is imprecise, but it could be phase 4-A, or phase 5 could be the continuation, patient continuation, if there's issues that need to be followed up.

Phase 6, if you will, would be referral to the emergency room or to the hospital for some additional issue. Phase 7 would be follow-up upon return from the emergency room/hospital to reassess and identify what additional issues

need to be addressed back in our care.

Next phase would be what we call enhanced medical monitoring where, if we have received people back who have significant illness such as they are diagnosed with the flu or something else, they will get enhanced medical monitoring or they'll get periodic checks and be monitored by the medical staff.

Next phase after that would be exit -- exit interview as appropriate, depending on their destination, be it travel, transfer, release, Marshal Service, ICE, HHS, et cetera.

So there is a very robust continuum of care that is provided, and that is not described in detail in this document by design. This document, again, was a waypoint, a snapshot.

Some of that additional detail will be in the implementation plans that are directed by this document, and some of those efforts continue to evolve, and so it's hard to capture them in writing in a formal policy document while they're still evolving and being enhanced.

Q. And just to clarify, so this Joint Exhibit 915 that we're looking at now, it's a Customs and Border Protection-wide document, it's not unique to U.S. Border Patrol.

Is that correct?

A. Correct. It's not unique to Tucson sector, yes.

Q. I just want to now talk about prescription medications and how that relates to detainees. What is your understanding

of the prescription medication policy in Border Patrol detention in Tucson Sector?

A. So if a person arrives with an issue, a question, a concern, or an existing supply of medication, in any way a question, a concern, an issue about medication or a preexisting supply of medication, that person will be assessed through the assessment process, through the interview, through the medical assessment, as appropriate.

If there's any question about their need for medication or the need to have a valid, current, accurate prescription, that will be addressed by our medical personnel on-site or referred to the hospital.

But we do not confiscate medication and not replace it or not have that evaluated. If we do -- if the medical personnel decides what prescription is required, then that medication will be filled. That prescription will be filled by us, and it will be dispensed in a controlled manner to the person in custody. And then, upon their departure, they will be given a supply of that medication to take with them.

Q. And do individuals always receive replacement medications?

A. Unless a medical provider determines that that -- whatever that -- whatever that medication was was invalid, was -- came from an inappropriate source, was not related to an actual medical condition, is not indicated at this time, you

know, our medical providers are not going to, you know, provide something that is inappropriate or harmful or dangerous to someone, and if there is any question about it, then that will be referred to the emergency room or to the hospital for a higher level evaluation or assessment.

Q. And what is the risk of harm to individuals maintaining their foreign-based prescriptions without supervision or confirmation from a domestic physician?

A. Well, we've seen all sorts of -- you know, sometimes we've seen what has been described as a prescription, and it's actually contraband. And it's -- you know, it could be fentanyl. It could be, you know, who knows what. It could have been -- it could have been handed out or prescribed by some disreputable pharmacist or organization.

We know very well that the pharmacy practices and the prescription practices in Central America and Mexico are nowhere near the level of reliability and of accuracy, if you will, as we have here in the United States. So in good medical practice, we can't -- we can't allow someone who's in our care and custody to be taking something that is suspect or might be harmful or might be dangerous.

That being said, we're not just going to leave it at that. We're always going to reassess and evaluate and identify the medical issues that might be in play, and we'll have professional, licensed, credentialed, certified medical

personnel make a decision about the prescription, and if it's beyond their scope of practice, maybe it's some complex seizure disorder or something like that, they will refer them to the hospital, to the emergency room, to a hospital, to have that further assessed or evaluated.

Q. And who checks the -- sorry. Once the prescription is filled, how is that administered in Border Patrol's stations?

A. That's -- that is dispensed in a controlled manner whereby Border Patrol, in cooperation with the medical personnel will hold onto the medication but will ensure that it's dispensed on schedule, in a timely manner.

From a law enforcement practices perspective, you can't just have a bunch of people, you know, in holding with various supplies and medications and you can't be certain if they're being taken, if they're being shared. There's potential for overdose, for any number of things. So it's standard law enforcement practice to dispense that in a controlled manner.

Q. And finally, what are the, in your opinion, the operational goals or needs of providing medical care in Border Patrol stations and detention?

A. Well, number one, we want to support the CBP mission, the law enforcement mission, as well as the mission of caring for persons in our custody, and that leads into number two, which is we want to ensure the well-being and safety of persons in our custody, to include ensuring that medical issues are

addressed as appropriate.

And number three, we want to address public health infectious disease issues. We want to identify them early and respond appropriately to them. And number four, we want to take care of our people. We want to enhance -- we want to make sure our people are comfortable with what's going on in their facilities and also that they're confident that medical issues are being addressed that could affect persons in custody, because of course it's a concern -- a very significant concern to our agents is the well-being of people in our custody, and so having medical personnel there helps with that, but also it reassures them that we're addressing issues that might impact them and/or their families when they go back home at the end of the day.

So it has a -- there's a number of rationales for it.

MR. CELONE: Thank you very much, Dr. Tarantino. No further questions.

THE COURT: All right. Cross-examine.

CROSS-EXAMINATION

BY MS. BALASSONE:

Q. Good morning, Dr. Tarantino.

A. Good morning.

Q. You've had a lot of experience with medical programs in various settings, but is it fair to say that you've never worked in a detention facility like a jail?

A. That is correct.
Q. And are you familiar with jail or detention standards, like, for example, the Standards for Health Services in Jails written by the National Commission on Correctional Health Care?
A. Yes. And I would say that I had no prior experience, but since I've been here, I have extensive experience. I've been to jails and prisons, and I've worked with ICE very carefully in their health system. I work daily with ICE Health Service Corps and with their health system because we interact and we're part of a continuum, so I'm very familiar with their practices and their approaches and their standards, and I've been to many of their facilities for the past two years.

So I have two years of very extensive, solid experience in that, but I didn't have experience prior to my job.
Q. Do the generally followed standards for medical screening and detention apply to CBP's medical screening?
A. I'm sorry. Could you repeat that? And I can already tell you it's going to need to be clarified, but maybe start by repeating it.
Q. Sure. Do the generally followed standards for medical screening and detention apply to CBP's medical screening?
A. Medical screening in detention?
Q. Correct.
A. Well, this is a difficult -- and we've discussed this

before. It depends on what you mean by screening. Screening means different things to different people, and it means different things in different settings. Screening, typically you're screening against a specific set of standards or a specific end state, such as screening for detention or screening for public health entry into the United States or screening for employment or screening for a school physical. So it has no meaning just by itself. It's setting-specific from a medical perspective.

And so we have developed -- we don't -- we don't even formally call what we do screening because we're not screening against a specific standard. We've developed a full, robust assessment process, which is a three-phase process. It doesn't just rely on a single quote/unquote screening form. It's a multifaceted process.

It's different -- if you're asking, is it the same as ICE's, is it the same as Bureau of Prisons', no, it's different, because we have a different setting. They're screening for detention into their facility for a long-term detention purposes. That's not what our mission is. That's not what our mission space is.

So our process is different. It's informed by and it's part of a continuum with, but it is different.

Q. And given your experience with ICE, would you say that the ICE screening is more robust than the CBP screening

because, in your view, ICE is doing screening for detention?
A. In some ways ours, you know, if you were to line the processes up 100 percent side by side, in some ways ours is more robust because it's more front-forward and it's more immediate. Some of theirs is a little bit more delayed in some areas. They look at -- they have to assess for very specific things that would be applicable to detention that we don't.

So it's different. I can't say one's better. You can't say one is better or -- they're different because they're in different settings.

Q. And the distinction you're making there is that CBP is not a detention setting, in your view?
A. Among other things. You know, our function is short-term holding, processing, onward movement to a place where we know these capabilities are going to exist. ICE is an end state place. CBP is a throughput place. You know, we can get into all sorts of hypotheticals, but the world that we operate in is that we know we're sending people onto ICE or HHS that have robust -- that do long-term detention and have robust medical capabilities and can offer additional services that it's not appropriate for CBP to have at its place in the continuum.
Q. And Dr. Tarantino, you testified that you're the Senior Medical Advisor for CBP; correct?
A. Yes.

Q. Are you also the Acting Chief Medical Officer at the moment for CBP?
A. Well, I don't think that that could be said. Maybe de facto, but I've not been formally designated that. We don't have a Chief Medical Officer right now. That position is, in my understanding, it's being developed, is being -- I don't know the right word. It's being established. But I'm essentially functioning in that role, but I don't have that formal title is the best I could say to that.

Now, I'm not trying to be evasive, but it's a little bit of bureaucracy involved in some of the terminology, perhaps, but...

Q. And so in your role as the Senior Medical Advisor, you testified that you provide medical direction and oversight for CBP medical efforts across all of CBP; right?
A. Yes.
Q. In that capacity, do you interact directly with EMTs who are stationed in the Tucson Sector?
A. Yes.
Q. And is that because they are operating under your medical direction when they do things like conduct medical assessments?
A. Excuse me. Yes. And we also have -- we also have local EMT supervisors, and we also have a local physician advisor here in the Tucson Sector. But the ultimate sort of medical

authority that they're operating under would be mine.
Q. Do you have direct contact with agents who are not EMTs who are stationed in the Tucson Sector stations?
A. Yes. That would be more limited. Again, you can imagine sort of a pyramidal structure. The farther out you get and the farther away from the medical arena, I would have less -- obviously we have, like, 65,000 people or something, so -- but I do interact. I've been out to Tucson Sector many times, and when I come, I go out with agents, as well as EMTs, and I talk to them at the stations and in their facilities. I did that yesterday, in fact. So certainly to an extent, yes.
Q. So there are multiple layers of people and communication pathways between you and sort of the agents who are doing -- agents who are not EMTs who are doing the day-to-day screening of individuals in the Tucson Sector; correct?
A. Right. I'm not -- I'm not going to try to say that I'm interacting directly with every agent on a day-to-day basis. Absolutely not. We have -- we have layers of communication. I am able to bypass them and go direct, and I do at times, and if there is an issue or a question or a concern or an event, then all those layers can be bypassed by people who have my cell phone number, and they know that they can contact me directly.
But you know, I'm not trying to fight your point. Yes, it's true that I definitely don't interact with, you know,

with all agents directly on a day-to-day basis. There is chains of command for that and lines of communication for that.

MS. BALASSONE: Mr. Lucero, please show the first page of Joint Exhibit 868 as admitted.

BY MS. BALASSONE:

Q. Dr. Tarantino, you testified that this is the statement of work --

A. I'm not seeing anything. Now I am.

Q. Okay. Great.

Dr. Tarantino, you testified that this is a statement of work that governs the medical contractor's role in the Border Patrol stations; is that right?

A. Yes.

Q. Okay. And this document explains why Border Patrol needs medical contractors to provide assistance in things like conducting screening; correct?

A. Well, this would apply to certain priority locations, and it would apply to certain points in the process. So like I said, we have -- they're supporting some of the phases, but other phases are done and doable and appropriately done by agents. And then there is a point at which there's an overlap and almost a -- I don't want to say a duplication, but there is a point where that comes together. And in fact, you know, we saw that yesterday in the sally port where the agents and

the medical is cooperating on doing the health interviews.

So I wouldn't say that this establishes a requirement that medical personnel conduct every phase or every aspect of our operations. We have long history and experience and practice in conducting some of the phases, and the system and the phasing that we have set up has been validated by a number of internal and external stakeholders, to include pediatricians, to include, you know, leading world experts on this, from the CDC, HHS, external parties, the Coast Guard, Public Health Service teams who are in our stations for months. All have validated these approaches and found them to be appropriate and reasonable.

So I would not agree that this document somehow establishes a need for contracted medical personnel to be leading or doing every single aspect of our operations.

Q. Is it fair to say that this document expresses a desire to have medical contractors participate in the health interviews, the second phase, for example, of medical screening in places like TCC?

A. No, I don't read it that way. I think a lot of the terminology in here, this is dated. This comes from -- was established five years ago, and some of the terminology has been adjusted, and some of our practices have evolved since then.

I think the core of this document is that we want medical

personnel -- and the way it's evolved is that we want medical personnel to be supporting our agents and to be providing the medical assessments and the medical care, the medical treatment, things that only -- only medical personnel can do. So that's the way I interpret it, and that's the way it is currently envisioned in terms of the guidance to the contractor and such.

Q. Looking at the third paragraph of the first page of this document, the first two sentences say, "As this population transits to the U.S., they may endure physically demanding and poor living conditions that adversely affect their health and well-being and pose increased public health concern upon apprehension and processing. The majority of USBP agents are not medically trained to effectively screen for and/or treat medical/public health concerns."

That's what it says right there; correct?

A. Right.

MS. BALASSONE: Mr. Lucero, please show the first page of Joint Exhibit 758.

BY MS. BALASSONE:

Q. Dr. Tarantino, do you recognize Joint Exhibit 758?

A. Yes.

Q. What is it?

A. This is guidance to the field to essentially implement what was called the interim medical directive that had been

signed earlier in that year.
Q. Were you involved in drafting this document?
A. Excuse me? Could you repeat that?
Q. Were you involved in drafting this document?
A. Not this memo. I was involved in drafting the document it refers to. I was aware of this memo, but this is from the Chief of the Border Patrol. But I also was involved in the guidance -- well, is there more to this document?
MS. BALASSONE: Mr. Lucero, could you please scroll through pages 2 through 8 of Joint Exhibit 758.
A. So yes, I was involved in this part of it. I was involved in that cover memo that was from leadership, but yes, I was involved in this, absolutely.
Q. And when you say "this," you mean starting on page 3 --
A. Yes.
Q. -- what's titled "The Medical" --
A. It's the direction, yes.
MS. BALASSONE: Your Honor, we request admission of Joint Exhibit 758 into evidence.
MR. CELONE: No objection.
THE COURT: It's admitted.
MS. BALASSONE: Going back to the first page, Mr. Lucero, please.
BY MS. BALASSONE:
Q. Dr. Tarantino, I'm looking at the second sentence of this

first page, which says, "These assessments by medical personnel may include in urgent circumstances United States Border Patrol (USBP) Emergency Medical Services (EMS)."

A. Yes.

Q. What is a medical assessment?

A. Well, as I've described before, that is a -- I try to define things without using the term that is in the definition, but essentially it's an assessment by medical personnel for medical issues of urgent or emergent concern that will need an encounter or a referral.

Q. When circumstances are not urgent, then are EMTs not supposed to do medical assessments? Is that a fair statement?

A. Well, the medical assessment is a little bit more of a formal process that was called out in the interim directive, so again, it gets into a lot of terminology and semantics. Certainly our EMTs are called all the time to evaluate and triage and even start immediate care and intervention.

This medical assessment, as we're talking about it here, is almost an additional collateral duty that we created some specifics about for our EMTs so they would understand exactly what was expected of them.

But in the course of their day-to-day work, they're responding to an emergency scene, they're going to assess that patient, they're going to initiate care, they're going to initiate referral. This medical assessment process that we

established as part of our assessment process was a little bit more specific, and so we had to give them some additional guidance, because they had questions about it, and we wanted to make sure they were clear on what the expectations were.

So we developed that detailed guidance. We also developed training, training materials, training videos, other things. We've incorporated this into their EMT training, their annual and refresher training.

And just to further clarify this, this is the -- when I'm talking about the three phases of the assessment, we have the observation and self-reporting, we have the interview, we have the medical assessment, this is referring to phase 3 of that, which generally speaking is going to be done by Loyal Source or referred to the hospital.

But during the peak of the crisis, we had, you know, significant issues with remote entry, groups of a thousand, hours from medical care, and so we were engaging and diverting and empowering our EMTs to step into that role as an additional layer as part of this sort of crisis response effort, and that's what this is about.

Q. And so medical assessments can -- now can be done by EMTs, government -- the LSGS contractors, or the local health provider; correct?

A. They can only be done by EMTs in quote/unquote exigent circumstances, which would be sort of an unusual really large

influx or a remote setting or some reason why it can't be done by Loyal Source or the local health system. And even were it to be done by an EMT, that -- eventually that person is still going to filter into the regular system anyway, and in Tucson Sector they're eventually -- they're either going to be at a hospital or they're going to be at the TCC one way or the other anyway, so this is just an additional layer, and it's an additional way that we can empower our EMTs who may or may not be available.

Q. And it's reserved for urgent circumstances because it would be preferable to have a medical contractor or the local health system do the medical assessment versus the EMTs having to do it?

A. Well, I would say it's preferable that it's done through our process, through our system. This is almost -- this is -- is alongside the system in the process whereby it goes from our feeder stations to the TCC to the local health system, if needed, onto ICE or HHS. That's the continuum, that's the process.

This is an additional sort of exigent capability that we have to lay alongside of that. And so, you know, ideally, we won't be doing that. Ideally we'll be using the flow in the process in the system that we have.

Q. I'm sorry. When you say -- excuse me. When you say ideally, ideally we won't be doing EMTs performing medical

assessments? That's what you mean?

A. Ideally the --

Q. And doing the normal route of contractors or local health system?

A. Yes. Ideally we'll use the normal continuum, which is what we were able to use during steady-state or limited-surge type of operations where we have the outlier stations, and then we funnel people to TCC, and we have Loyal Source, we have the health system, we move people onto ICE and HHS.

And that's -- that's the way the system is designed, but we build in -- we tried to build a system that doesn't have a single point of failure and that also has layers of defense, and this is an additional layer of defense because we have this unique capability, which is our EMTs, and so we have them available as appropriate in sort of limited circumstances.

THE COURT: Counsel -- counsel, let me interrupt you. We need to take a recess. I mean, we're not working very hard, but Erica is. She needs a --

MS. BALASSONE: Absolutely.

THE COURT: She needs a break. So let's take a recess for 10 minutes.

THE WITNESS: Yes, Your Honor.

(Recess taken.)

THE COURT: All right, counsel. Go ahead.

MS. BALASSONE: Thank you.

BY MS. BALASSONE:

Q. Dr. Tarantino, you testified that there are medical contractors at TCC; right?

A. Yes.

Q. And you testified that they started in the summer. Is that the summer of 2019?

A. Yes.

Q. You also testified that there are medical contractors in Nogales; right?

A. Yes.

Q. And you testified that those contractors started in Nogales in December of 2019; right?

A. Yes.

Q. You testified that medical -- the medical contractor structure is still in an expansionary phase. Are there plans to have medical contractors at any other station in the Tucson Sector besides TCC and Nogales?

A. Well, that's something that's constantly being assessed based on the operational risk management methodology, so I am not specifically aware of a set decision to establish a specific additional location on a specific date, but I know it continues to be assessed based on evolving conditions, availability of resources, as we continue to -- are able to put resources to the contract, and the contractor's able to hire additional persons, and then we identify the next

operational priority locations based on the parameters that I've discussed before.

Q. Is there any long-term vision, excuse me, to have medical contractors stationed everywhere in the Tucson Sector?

MR. CELONE: Objection, Your Honor. I'm just concerned that some of this line of questioning might get into deliberative process, so I would just like to keep that in mind as the examiner is asking questions.

THE COURT: Okay. I don't really know what that means.

MR. CELONE: I mean, as the -- I'm concerned that the witness may be encouraged to disclose processes that are under consideration by Customs and Border Protection, and those are privileged under the deliberative process privilege.

THE COURT: Okay. We don't want to --

MR. CELONE: I haven't heard any concerns just yet, but as this line of questioning goes on, I just want --

THE COURT: Well, let's wait until we hear your concerns.

Go ahead. Answer. He can answer the question.

A. Did you finish it? Could you repeat it?

Q. I sure can. Is there any long-term vision to have all stations in the Tucson Sector have medical contractors?

A. Well, I think there is a long-term vision to right-size our medical footprint based on the operational risk and

operational risk management assessments that are made.

I could certainly envision a circumstance where an additional station might require medical support, but I can envision scenarios where a station might not, and we don't just put medical teams out in stations if there's not going to be the appropriate volume or workload or -- we have to be diligent about resources and about taxpayer dollars and about, you know, having professionals engaged professionally instead of just sitting and waiting.

So there is a long-term vision to right-size the medical footprint, and that's going to continue to be informed by operations and by volume demographics, remoteness, access to care, time in custody, crowding, or not crowding, but volume and census and those sorts of factors.

Q. You testified that there are shifts in contractor resources from time to time; is that correct?

A. Yes.

Q. So is it possible that the contractors currently at TCC could be removed if, under the factors you identified, it's determined that they shouldn't be there?

A. Well, it's hard to speculate about hypotheticals. I think, you know, in the realm of anything being possible, you know, you could talk about a lot of hypotheticals. My understanding is that the -- my understanding and my intent and my guidance and my advice is that the medical support

requirement at Tucson Sector, TCC, has been validated and is valid, and the intent is to continue this contract. This contract is not a short-term stopgap measure. It's meant to be a long-term solution.

Now, could you imagine a hypothetical in some location, maybe not even in Tucson Sector, where we currently have medical support, but then, for whatever reason, we go six months where not a single person is brought into holding or custody? Would we then, in that hypothetical situation, look at moving that medical team somewhere else? I would have to say almost certainly.

But again, you're getting into a lot of hypothetical situations. I don't see us as being anywhere near that at the TCC, but, you know, the construct is meant to be scalable and flexible and adaptable to operational circumstances, and I think that's how it will unfold.

But I do not envision, have not heard any talk, I don't personally see any time on the horizon a driver to change the medical support at TCC, if that's what you're asking.

Q. And the same --

A. Well, I mean, that may not be what you're asking, but I'll make that point.

Q. And the same is true for Nogales, that there is flexibility built into the approach such that at some point they could not be there, the medical contractors?

A. Well, I would just go back to my same answer, that there's a lot of hypotheticals involved, but for Nogales, I haven't seen any indication or have not been party to any discussions and my recommendations have not changed that the medical support -- the requirement for the medical support at Nogales Station is valid and should continue, and the intent is to continue it, you know, essentially indefinitely.

Like I said, this is a long-term solution. It's not a short-term stopgap solution. This is a -- the entire effort across the whole southwest border is an ongoing long-term effort in the eyes of the CBP leadership.

Q. And as things stand now, the medical contractor arrangement could end in the future if Border Patrol decides not to spend the money; right?

A. Well, I think it's the reverse. I think what could end it is if it's not funded, it's not appropriated funding by Congress, because obviously it costs money, and the contractors aren't going to work for free. So CBP and Border Patrol are committed to it. You can see it in that document, that directive. That's CBP policy, and it specifically talks about the contract.

But if you read that document -- I'm not saying you haven't read it, but if you -- if you look at it, it speaks to the requirement for funding, which is out of CBP's control. So it has to have the funding from Congress appropriated to

fund this effort because it's, you know, it's a financially intensive effort.

But that is not -- that is not a CBP or Border Patrol issue, in my perspective. That's a congressional funding issue. CBP and Border Patrol have signed on for this in writing, in that directive that was an exhibit already.

MS. BALASSONE: Mr. Lucero, please show page 1 of Joint Exhibit 915 as admitted.

BY MS. BALASSONE:

Q. Dr. Tarantino, you testified that this directive captures or codifies where CBP is right now for the Tucson Sector; is that right?

A. This is a broad high-level document. It doesn't get into a level of detail such that -- it doesn't speak specifically to a medical team at TCC, but it speaks to the operational risk management methodology which was used to identify the requirement at TCC.

So if that answers your question, that's my answer to that.

Q. So in the future, there could be additional directives or policies that scale down the kinds of efforts that are described in this document?

A. Well, and can policy be changed? I think policy can be changed. All I can speak to is that this is the current policy of Department of Homeland Security, U.S. Customs and

Border Protection, and Border Patrol. This is the policy that captures the direction that we're going in, which includes the contracted medical support at high-priority locations as identified through the operational risk management methodology, which in this case includes TCC and Nogales.

So this is in writing, and one of the reasons it was put in writing was for questions like this. It was put in writing as official policy of the U.S. Government. So that's where we are now.

Q. And you testified that Tucson Sector is doing more than what this policy describes in that it's doing health interviews for all detainees, and it's doing medical assessments for all kids, even those between the ages of 12 and 18; correct?

A. 13 and 17, but yes.

Q. Thank you.

So is it possible that those additional efforts that Tucson Sector is doing at the moment they could decide not to do at some later point?

A. Well, my understanding of the Tucson Sector situation is that -- well, let me just say that this is our practice across the border, is to do health interviews on all persons where we have the medical support at a minimum, because where we have medical support, we health interview everybody who comes in, this is other sectors, and all juveniles. So that's our --

that's our practice everywhere.

We weren't able to commit to that formally in writing because there are some locations that don't have medical support yet or are so remote that that's just not going to be feasible. But within Tucson Sector, my understanding of the situation here is that there is a separate requirement, I think it was maybe imposed by this Court, to do health interviews on all persons, and that's why -- that's one of the reasons or I think why it couldn't be relaxed, because of that.

But our guidance, again, is at-a-minimum guidance, where you have the resources, such as the medical support at TCC, then the health interviews should be on all persons, and the medical assessment should be on all juveniles. It's when you get to places where you don't have resources or you get into some really exigent circumstances where we fall back to that minimum standard.

Q. Would you agree that this document talks about where medical contractors are and talks about operational -- things that are caveated as where operationally feasible?

A. Yes, and I'm aware of the -- of the concern about that and the subject to interpretation nature of that. Certainly there was a lot of discussion of that as this document was built. That was meant to capture situations such as a mass migration that just completely overwhelms available resources

and/or congressional -- if Congress for some reason deappropriates funding for this, which these are things that are out of CBP control.

It's essentially, I'm not a lawyer, essentially a force majeure type of situation or some situation whereby CBP just can't do -- can't do these things because they're just overwhelmed. And that becomes a U.S. Government solution versus a CBP solution. This is a CBP document, so that can't be written into here.

If we get into those situations where the funding doesn't exist and then CBP will need Congress or someone else to give them funding, that can't really be written in here because this is a CBP document, or we need those Public Health Service or Coast Guard teams again. That can't be written in here because this is a CBP document. We can't commit them to things in here.

But we are having those discussions, and we do have plans with them to have those surge capabilities, but this is kind of a focused, high-level snapshot-in-time CBP document. It shouldn't be interpreted as some sort of absolute restriction, you know, an absolute box around our efforts. It's sort of -- it's sort of a snapshot in time of where we are and where we're going.

Q. But if this document already contemplates caveats for operational feasibility and where medical contractors are

located, why doesn't it say what the Tucson Sector and other sectors are actually doing with regards to health interviews and medical assessments, with those caveats?

A. You mean why doesn't it -- why doesn't it capture what's happening at every -- at every station along the southwest border?

Q. Well, my understanding is you testified that Tucson Sector is already doing other things that are not in this policy; correct?

A. Right.

Q. And that the goal is for all sectors to be doing that on the southwest border, which is what this policy applies to, with the exception of where it's not operationally feasible and where there aren't medical contractors.

So why doesn't this document reflect what is actually being done with those caveats?

A. Well, I'm not sure -- a hundred percent sure I'm following your question, but it is not -- because this is a constantly evolving and enhancing process, and there's other sectors that are in a different stage of the evolution, and it's -- if this -- if we had captured that in November, it would have changed -- for Tucson Sector, it would have changed in December, because Nogales was stood up. And then it will change in January. It will change in February.

We have to have at some point a static snapshot of a

dynamic process, so it's very hard to capture, you know, the level of detail you're talking about in a static document when it's describing a very dynamic process. And so that's the best I can say to that.

And that's why I caveat it that, the direction is that this is a snapshot in time. It's maybe -- it's the marching orders to march onward from and continue to improve and enhance our efforts. It is not meant to say this is set in stone forever, and we'll never do any more than this, and if anyone ever tries to do any more than this, then that's wrong. That's not what it represents.

Q. So looking at this document, how does a Border Patrol agent in TCC or Nogales know that they are supposed to do health interviews, or anywhere in the Tucson Sector, know they're supposed to do health interviews for everyone?

A. Well, that hasn't changed. This document did not change that. So they would have already known that, and they would continue to know that, and they would continue to get that guidance from their sector leadership, and this document does not -- does not change that in any way.

Although I guess maybe, I think it's in this document, the one thing that's changed is the form has been enhanced to some degree, and that -- but that is in the e3 system, so they just continue to fill out the form. They'll notice -- and we're told that there's some subtle changes to it, but they'll

continue doing what they've been doing and completing the health interview form in e3, slightly modified and updated.

So this directive does not change that, and the practices in that regard have not really changed.

Q. So if it's not explicitly in this document, what assurances are there that the Tucson Sector is going to keep doing what it's doing in terms of efforts that are not outlined in this policy document?

A. I guess you're saying if somehow the other requirement to do it were removed or something? Because we know that there's a requirement to do it in Tucson Sector.

Q. My question --

A. And so that's not going to change. We're not going to violate a requirement.

Q. And by "requirement" you mean requirement by this Court to do a health interview?

A. Right.

Q. And so if this Court were to no longer require Border Patrol to do a health interview, are there any assurances that the stations in the Tucson Sector would continue to do it for all people?

A. That would continue to be the intent and the practice. Now, would there be -- is there a possibility that, in some exigent circumstance such as, you know, a mass migration or a group of a thousand, that that might be delayed or might be

prioritized to juveniles, which is the -- and one of the main aspects of this is that it's really meant to really focus limited resources on to the vulnerable populations of juveniles.

So could there be a circumstance whereby, in some exigent circumstance, mass migration or a remote location or a group of a thousand, that juveniles were prioritized? That could be the -- that could be the case. But the intent -- the guidance and the intent and the practice is to do it on all -- I'm sorry -- to do the health interview on all persons in custody.

Q. So turning to health interviews that are performed at TCC, you testified that those health interviews are performed by either agents or medical contractors; right?

A. Well, the intent is that they can be, per this document, they can be done by agents or medical personnel. At the TCC, the practice is it's actually done by both, and it's done collaboratively. They're right there in the same location. They're side by side. They're near each other.

So agents will be asking these questions and documenting them. The medical personnel will also be asking them and examining the patient and relaying any of those findings to the agent, who can make sure it gets documented, and the medical person can take any action that's appropriate immediately or refer -- take them, escort them for medical assessment, or declare an emergency or a public health issue

and proceed with masking and isolation, referral straight from there, 911 or transport to the hospital.

So it's -- there is some redundancy, and there is -- and it's done collaboratively.

Q. And by collaborative -- collaboratively, you mean -- are they done at the same -- is the contractor and the agent doing the health interview at the same exact time together, or are they doing them separately at different times?

A. Well, I don't think either of those is right. They're doing it in a collaborative manner where they're -- each is doing health interviews, but they may be -- they may be overlapping. There will be -- some will be separate, there may be some overlapping, and then there may be -- so it's done, you know, it's -- I went and saw it, and it's a very well-choreographed dance, if you will, that they have down pretty well, and so the health interview is being conducted through an agent's prism but also through the medical prism, and it's getting documented, and the appropriate actions are being taken, and it's going quite well for a relatively newly -- you know, newly advanced, newly adjusted process.

And we continue to learn lessons from it, and I got some feedback from one of the agents yesterday. I talked to the medical person who's doing it. We'll continue to, you know, adjust the implementation or the execution of it. We're not adjusting the intent, but we can continue to refine and

enhance our processes from a systems perspective.

But it's going very well, and it's a very robust process.

Q. And you testified that the agents fill out the alien health interview questionnaire form; correct?

A. Yes.

Q. And you also testified that the medical contractors ask questions, but they don't fill out the actual form; is that correct?

A. They will inform the agent who will fill it out. So it will be doubly verified, essentially. And so we're not going to have two separate, perhaps, potentially conflicting health interview forms completed. They will work with the agent to put their inputs in along with the agents. And so it will be in our electronic systems, is the key point, to have it in e3.

Q. And that's something the agent does that they take the information from the medical contractor, and the agent is the one who fills out the alien health interview questionnaire and then puts it in e3DM?

A. Well, it's part of -- it's not like and then they put it in. It's in. It's part of it. It's integral to it. But they enter it in there, yes.

Q. So since the contractors aren't filling out their own alien health interview questionnaire forms, are you just relying on the reports that they are doing it, or how do you know that it's actually being done?

A. Well, I went there and watched and saw it being done, and I know that as part of our -- we have task order monitors in place who monitor the contractor to make sure they're completing the required tasks. We have contracting officer representatives who monitor the contract. We also have medical quality management processes in place. We've also incorporated this monitoring into the work of our juvenile coordinator who goes out and looks at monitoring and compliance of our medical support efforts, to include the health interview and the medical assessment.

So there is layers and layers and layers of review of that, but also, you know, right back to the point of origin, if you will, it gets entered. It does get entered directly into e3, without delay, without chance for forgetting or missed documentation. It gets entered directly in, and it has two sets of eyes and two sets of perspectives that are essentially duplicating that process and entering it straight in, straight into the system.

Q. But that entering of the system is being done by the agent; correct?

A. Yes.

MS. BALASSONE: Thank you. No further questions.

THE COURT: Any redirect?

MR. CELONE: No redirect, Your Honor.

THE COURT: Doctor, I appreciate you being on board

to attend to the medical issues for these people that are detained. I have a couple of clarifying questions, if I may.

Would you bring up Exhibit 881.

MS. BALASSONE: Would you like that on the screen, Your Honor?

THE COURT: Yes. Let me see if I can find this testimony.

Yeah, that's the standard form that's now being used?

THE WITNESS: Yes, sir. Yes, sir.

THE COURT: All right. We had a witness testify in the case that, in his opinion, that wasn't adequate, and he was critical of that form because there was nothing in it about dental or dietary needs, suicide ideation, fever, cough, night sweats, alcohol abuse, sexual abuse.

Do you have any comment about that observation?

THE WITNESS: Well, sir, first of all, I think the majority of those things are in there, and if we wanted to go through them, I'm not contradicting you, sir, if we want to go through, it does talk about fever.

It does talk about suicidal ideation, which we kind of -- the layman's short-term for that is, "Are you thinking about hurting yourself?" Generally in practice you don't just say, "Are you suicidal?"

So we said, "Are you thinking about hurting

yourself," and that was in consultation with a number of experts, "and/or others," is homicidal. So you don't say, "Are you suicidal?" "Are you homicidal?" We say, "Are you thinking about hurting yourself or others?"

And so a lot of those are in there, but I think that person's perspective may be a detention level, sort of intake screening for detention level, and when you get into some of the things -- yes, we don't ask about dental specifically, but that would come out of pain, ill, injured, pain, are you having any other issues, certainly if someone is having some dental pain, that falls under observation.

So at some point this form, there was a real tension between packing everything into this form to the point where it's not going to be feasible to be done operationally and we won't be able to do it on as many people and getting the real critical highlights in there that need to be in a form that's operationally feasible.

And we didn't cook this up on our own. It was done -- it took literally months and months and months. It was done through a very collaborative process with inputs from internal -- internal CBP operations, medical privacy, CRCL, which is Civil Rights/Civil Liberties Division, DHS Headquarters, physicians at that level, physicians in Public Health Service, in CDC.

We also talked to external groups about things. We

looked at other examples that I knew from my career that we use in refugee centers, that we've used in disaster settings, from FEMA. So we looked at a number of examples, and we consulted widely, and this is what came out of a very lengthy and involved deliberative process.

THE COURT: All right. Well, I'm not being critical of it because I don't know enough.

THE WITNESS: Sure.

THE COURT: This was a witness in the case.

THE WITNESS: Understood.

THE COURT: And he used an example I think about drug/alcohol abuse, because there might be some pain/discomfort associated with that --

THE WITNESS: Yes, sir.

THE COURT: -- if there's a severe alcoholic or something like that being in custody. There might be some issues, obviously, related to sexual abuse that's relatively -- I don't know if it's common, but happens a lot that there's abuse along the way, along the travel way, for these people, and he was critical of that form because of some of those omissions.

THE WITNESS: Yes, sir. The abuse question, that comes up in other lines of questioning as part of the law enforcement process, which I think is involved in that -- that would -- we have to look out for trafficking of persons and

identify other legal, you know, illegal things that may have happened or been happening, so -- but we did not -- there was not a broad consensus to include that in here specifically. We do ask about drug use, "Are you a drug user?" That question is in here.

So, you know, it was -- you know, will well-meaning experts look at this form and come up with another question that they would like to see on it? Absolutely, and that was part of this really ongoing deliberative process, and we ended up with this. The key point was in no way to regress from the prior form, so there's nothing that was in the prior form that isn't addressed in here.

THE COURT: Got it. All right.

Well, I may have been the problem with Exhibit 915, that's that phases used at intake. Let me come at it a different way.

We're looking -- first place, we're looking at it with legal minds --

THE WITNESS: Yes, sir.

THE COURT: -- some great and some small, but we look at it as lawyers, and when I see a document that says that something be done at a minimum, I read that to mean that an officer could conclude that we have to treat these juveniles differently, we have to do that, but we don't have to do adults because it says at a minimum. That was the

reason for all these questions.

Now, maybe it is a question of, when you describe it, 915, as a high-level document, is that to say that it really doesn't go out into the field? It's for management and supervisors as a policy statement?

THE WITNESS: It is. It is a high-level policy document, sir, but it has been pushed out to the sectors and to the field to guide their operations, but --

THE COURT: Oh, okay.

THE WITNESS: -- there are going to be detailed implementation plans which will be much more oriented towards the operators at the sector and station level, and we're working with them on that now to build those -- those implementation plans that will have additional detail.

THE COURT: All right. Well, here was my intent with the preliminary order issued in this case, that all detainees upon intake get a medical screening.

And you've been asked some questions. If an order is preliminary, that means it expires. Does the Border Patrol have to be ordered to do a medical screening for all detainees? Put another way, is there a written directive of any type out in the field, in the Tucson Sector, that's what I'm -- that's what I've got jurisdiction of in this case, not Rio Grande, Tucson Sector -- is there a written guideline or directive to all Border Patrol personnel that a medical

screening must be done for every person that comes into custody?

THE WITNESS: Sir, if you're -- if you are sort of equating screening to our health interview --

THE COURT: I am.

THE WITNESS: Okay. That helps. Then I can't personally vouch for a current written document in the Tucson Sector. I know that that is the guidance. I know that that's the policy in the Tucson Sector. I know that's the practice. I can't say that I know of a current, specific Tucson Sector policy document in that regard, but I do know that that is the policy.

So it's a fair question, obviously. By definition you asked if it's fair. But I can't answer specifically about that document.

THE COURT: How can I rely on the fact that it will be done in the future?

THE WITNESS: Well --

THE COURT: I mean, you know, that's the nature of injunctive relief. Let me give you a gross example. Let's say Border Patrol was ordered to put beds in. Well, those beds can be taken out; right?

THE WITNESS: Yes, sir.

THE COURT: The same with respect to this screening process?

THE WITNESS: Right.

THE COURT: If the Border Patrol is not ordered on a permanent basis to do medical screenings, they can just quit doing them?

THE WITNESS: Yes, sir, and what I would say is, Border Patrol is permanently ordered now to do health interviews/screenings on all juveniles.

THE COURT: Right.

THE WITNESS: In Tucson Sector, they are ordered to do it on all -- all adults or all -- everyone, to include adults. So -- but that is specific to Tucson, and it's specific to your injunction, if that's the right term.

Going forward, if that is relaxed, could Tucson Sector, you know -- but I will say that the intent and the guidance is to do it on everyone, to do it on all individuals, to the extent possible, but you absolutely have to -- you have to do it on all juveniles, because that's our top priority.

And I can tell you how that came out in that directive, why it says health interview on all, minimum, all juveniles, is because the juveniles are thought to be an especially vulnerable population who oftentimes are unable to speak up for themselves. Sometimes they don't have the awareness to know if they have a symptom or something or their history. And they deteriorate more quickly than adults, and sometimes their symptoms are masked.

That's why the decision was made to have that demarcation where we've got to get the interviews on all juveniles. Adults, more likely to be able to be observed, self-report, understand what's happening, and not be -- they're more likely to come forward.

So that demarcation was essentially accepted and approved by the experts and all the parties in CBP and DHS, and it was socialized across the U.S. Government, to a large extent, and that rationale was accepted, where it says, if capable, if able, if the resources are there and we're not under a giant influx, we're going to do health interviews on everyone, but we're really putting a marker down as, we'll be out of compliance if it's only juveniles.

Of course you're free to do what you -- what you want to do.

THE COURT: Yeah.

THE WITNESS: Obviously.

THE COURT: That's the problem. And of course I can be wrong.

Do you think, in your opinion, in your medical opinion, do you think it's necessary to have at least some type of medical screening process in place for all persons taken into custody?

THE WITNESS: I think the way we have that directive written now is a very good balance of the operational sort of

realities that we work in, plus the medical prerogatives that I need to enforce, and so I know that I'm building a system and we're building a system whereby, where we have the medical support, which is increasingly -- increasingly at any -- at any high-volume facility, everyone is going to get the health interview.

Now, there may be some outliers and some circumstances where juveniles get prioritized. I am comfortable with that medically. It's -- I always -- I don't want to -- I always would feel bad about signing us up for something that we know we might fail at. If we commit all day, every day, all the time, we're going to do health interviews on everybody, no matter the circumstances, that's a very high bar.

We have said, all day, every day, whatever the circumstance is, we're going to make sure we get it done on juveniles, and we're going to strive on a daily basis to do it on everyone. I'm comfortable with that. I think it is reasonable, because we have other fail-safes in the system. We have agent observation. We have self-reporting. We have a low threshold for referral to the health system, if any issue appears to be going on.

We look at patterns in terms of adverse events, deaths in custody, you know, and we see, was that because there was not a health interview or something like that? We

haven't really been able to show that or show data on that. You know, we haven't seen -- you know, although I think the order to have the universal health interview in Tucson was clearly well-intentioned, and -- but we haven't seen, you know, a marked difference in terms of outcomes between Tucson Sector, where they do it on everyone, and other sectors where they may do it on juveniles, probably for the reasons that I said, that adults, it's easier to tell if they're sick, they're more likely to come forward, and in most cases we are doing it.

So certainly reasonable people could disagree on this issue, but I think, when you're balancing the operational and the medical, I think the way we have it laid out and the direction we're heading, and to continue to give us the discretion to continue to enhance that as resources come on, I think is a very reasonable medical -- can be very reasonably justified medically, and a lot of other experts who looked at it thought so also.

And I'll take it even one step further, because the medical assessment, we say tender age children, and why is that? Because that's a subset of an at-risk population, the preteen. Everyone will have gotten a health interview, but the preteens are even more able to come forward and represent themselves, and the preteens, they're less likely to deteriorate as quickly.

So we had pediatricians look at that, and they said, on the medical assessment piece, that is reasonable, because it's pretty intensive. Doing a medical assessment is pretty labor intensive. It takes time. It can back up our processing. And ultimately, the more medical we lay on and the more processes, the longer we prolong the custody, which isn't good for anybody, because ultimately CBP wants to be as efficient as possible to move forward people through.

THE COURT: Well, does the use of Form 881 on all detainees coming through the process seriously impair the function of Border Patrol in its mission?

THE WITNESS: In a day-to-day-type setting, no, but if you get into -- as you get into a heavy surge or a crisis or you get a group of a thousand, which we've had, I'm sure you're aware of that, to then have to stop and formally do this on every single person, that is a significant operational challenge, and it's a significant undertaking. And it does -- it does slow things down.

That's not to say it's not well-intentioned, but there's always a balance, and we're trying to thread that needle and walk a fine line and make sure medical is given the same consideration as operational, because CBP does not want any bad outcomes in our custody. It's not like we're trying to cut corners, because nobody bears the brunt of a bad outcome more than our agents who witness it and have to live

with it, and of course we bear all the repercussions of it.

So we do not want any bad outcomes, and we're trying to navigate that. It's a very difficult environment. I understand how it looks from the outside, but from the inside, we're really leaning forward to ensure that the right care at the right time to the right person is happening.

THE COURT: Do the El Paso and Rio Grande Sectors do medical -- some kind of a medical screening on all detainees?

THE WITNESS: The practice that I've been describing is pretty universal. They are not required to do the health interview screening on all individuals. The practice is to do it where we have the medical support.

And the point is, where we have the medical support, it's easier to do on everybody, because we have that additional support, and it takes some of the burden off the agents. Where we have these more remote small stations, only a small handful of agents, that's where it gets hard to demand that they do it on everybody, and especially because a lot of times people will only be there for not too long, and then they're going to end up at another one of our feeder stations, and it gets done there, where we have medical.

So in other sectors, per our policy, they are not required to do a health interview on all persons, but the practice is to do it --

THE COURT: Gotcha.

THE WITNESS: -- where I have medical. And in those sectors, RGV and El Paso, they've obviously been busier sectors, we have a bigger medical footprint, and so they're more able to do it.

THE COURT: All right. Nice discussion.

Did that lead to any questions from counsel? Any further questions?

MR. LONDEN: There's nothing we need to ask, Your Honor.

MR. CELONE: Nothing further. Your Honor.

THE COURT: All right, Doctor. Thank you very much for coming here to talk to us.

THE WITNESS: Yes, sir.

THE COURT: You may be excused.

THE WITNESS: Thank you.

MR. CELONE: Your Honor, just for clarification, is the witness dismissed or excused? Because he has a flight back to D.C.

THE COURT: Yes. He can leave; right?

MR. LONDEN: (Nodding.)

THE COURT: Okay. Take off.

THE WITNESS: Thank you.

THE COURT: Big day in D.C., I'm sure.

THE CLERK: Please raise your right hand.

DIANE SKIPWORTH, WITNESS, SWORN

THE CLERK: Thank you. Please be seated.

If you'd state your full name and spell your last name for the record.

THE WITNESS: Diane Skipworth, S-k-i-p-w-o-r-t-h.

THE COURT: How do you do.

Go ahead, counsel.

DIRECT EXAMINATION

BY MS. PARASCANDOLA:

Q. Ms. Skipworth, would you please tell us what certifications you possess.

A. I am a registered dietitian, a licensed dietitian, a registered sanitarian, a certified correctional health care professional, and I'm certified in laundry and linen management.

Q. What's the difference between a registered and a licensed dietitian?

A. A registered dietitian is a national credential, and it's registration through a national organization, whereas my licensure is through the State of Texas.

Q. And what does -- what's required to become a registered dietitian? Do you have to have an undergrad degree?

A. Yes. I have a bachelor of science in dietetics or nutrition and passed an examination and then maintenance through continuing education.

Q. And what is required to become a registered sanitarian?

A. Also educational requirements and passing of an examination and continuing education.
Q. And when did you become a registered dietitian?
A. In 1993.
Q. Okay. And when did you obtain your state licensure?
A. In 1993.
Q. And when did you become a registered sanitarian?
A. In the late '90s.
Q. And when did you become a certified correctional health professional?
A. In 2015.
Q. And when did you become a certified laundry and linen manager?
A. I can't remember the exact date at the moment, but it was in the early 2000s.
THE COURT: I've never heard of that. That's awesome. There's a laundry and what did you call it? Laundry and --
THE WITNESS: A certified laundry and linen manager. It's -- I had to learn a whole lot about things that most people probably don't care about.
THE COURT: Yeah. Uh-huh.
BY MS. PARASCANDOLA:
Q. And do you possess any degrees?
A. Yes. In addition to a bachelor of science in nutrition

or dietetics, I also have a master's degree in criminal justice.

Q. And when did you obtain your bachelor of science in nutrition?

A. In 1993.

Q. Are you currently employed?

A. Yes. I'm employed by the Dallas County Sheriff's Department in Dallas, Texas.

Q. And how long have you been employed there?

A. A little over 25 years.

Q. And what is your title?

A. I am the Director of Detention Support Services.

Q. And what exactly do you do there?

A. I oversee the food service and laundry sections of the department.

Q. And do you have any other recent professional experience outside of your work for the Dallas County Sheriff?

A. Yes, I do.

Q. And what would that be?

A. I do contract work for the Department of Homeland Security for their Office for Civil Rights and Civil Liberties, and I'm also a monitor for the Court. I monitor food service for Orleans Parish.

Q. And with the second item that you just discussed, is that -- are you a court-appointed monitor?

A. Yes.
Q. Okay. And is that in connection with a court case?
A. Yes, it is.
Q. And what is that?
A. It's the Lashawn -- the Lashawn vs. Marlin Gusman case.
Q. And is that in Federal Court?
A. Yes, it is.
Q. Okay. In the District of Louisiana?
A. Yes.
Q. Okay. And have you also done any outside work for the Department of Justice?
A. Yes, I have.
Q. Okay. And what was that?
A. I have done work for their special litigation section. I've gone to a jail and a women's prison and done some consulting work for them as a subject matter expert.
Q. And these -- your subject matter in these projects was environmental health in the correctional environment?
A. Yes, and one was specifically nutrition.
Q. Okay. And have you ever testified in court as an expert witness?
A. Yes, I have.
Q. And what matter was that?
A. That was a case in Mississippi. I was plaintiff's expert for the ACLU.

Q. Was that Dockery v. Epps?
A. Yes. I believe that the name changed towards the end, but that was the initial name, was Dockery v. Epps, yes. Epps changed at the end.
Q. And in what area of expertise were you qualified in, in Dockery v. Epps?
A. Environmental health and safety.
Q. And who retained you in that litigation?
A. The National Prison Project for the ACLU.
Q. And what was that case about?
A. Conditions in a prison in Mississippi.
MS. PARASCANDOLA: Your Honor, at this time we tender Diane Skipworth as an expert in environmental health, nutrition, and sanitation.
MS. MAYER: Without objection, Your Honor.
THE COURT: Okay. Accepted.
BY MS. PARASCANDOLA:
Q. Ms. Skipworth, did you prepare a report in this case?
A. Yes, I did.
Q. And on what date did you finish and sign the report?
And you can -- if you can't remember exactly, a rough estimate is fine.
A. It was late October/early November of 2017.
Q. And do you still stand by the opinions in your report?
A. Yes, I do.

Q. What information did you consider in writing your report?
A. I considered quite a few things. I did a site visit of different Border Patrol Stations in the Tucson Sector. I looked at a number of documents. I looked at some video, a variety of different things went into my report.
Q. Well, let's talk about the visits to the Border Patrol stations. So would it be fair to say that the first visits were in 2015?
A. Yes.
Q. Okay. And around the week after Thanksgiving?
A. Yes. It was the Monday, Tuesday, Wednesday after Thanksgiving in 2015.
Q. Okay. And how many stations did you visit approximately?
A. I believe it was five, I believe. Four or five. I think it was five.
Q. Okay. And the next time you visited Tucson Sector stations was that in September 2017?
A. Yes, it was.
Q. Okay. And how many stations did you visit?
A. I visited five stations.
Q. Do you remember what they were?
A. Yes. The Brian A. Terry Station, the Ajo Station, the Sonoita Station, the Willcox Station, and TCC.
Q. And did you visit any Tucson Sector station subsequently?
A. Yes. In the latter of 2019, August 21st, 22nd, and 23rd

of 2019, I went to five different stations in the Tucson Sector.

Q. Do you remember what they were?

A. Yes. I went to Nogales, TCC, Douglas, Brian A. Terry, and Ajo.

Q. Did you use any special equipment on these inspections?

A. Yes. I used standard tools that I use on all of my inspections: a thermometer to measure air temperature, a tape measure, standard things I take with me. I took a camera as well to take some photographs. That helps me remember what I saw after the fact.

Q. And during the site inspections, were you denied access to anything that you needed to inspect?

A. No, I was not.

Q. Would it be fair to say that all of the stations have more or less the same facilities, that is, they have, as the Court was discussing yesterday, the sally port, the interior entrance area where people go through a metal detector, the processing area, the hold rooms, one or two hold rooms reserved for showers or self-cleaning, a supervisory observation area or what the agents call the bubble that allows direct visual observation of the processing area and hold rooms and has computer monitors streaming video, an EMT room where basic first aid supplies are stored, a storage for janitorial supplies, a designated area for storage of sleeping

mats, a room for food preparation, a room for food storage?

With some variation do all the stations have this same basic layout?

A. Yes. I mean, all -- the stations vary somewhat. Some are smaller. I mean, obviously TCC is larger. But all the stations have a very similar layout. There's a sally port where the individuals come in. They're preprocessed. You know, the food preparation area, some had a room, some had a much smaller space.

But overall I think that they all had a bubble or also kind of known as a control center, but yes, they all have a similar layout. That's a fair characterization, yes.

Q. So can you tell us what areas of the stations you visited during your inspections.

A. Yes. I mean, I visited the sally port of all the sections. I kind of did a -- asked to be walked through the way an individual coming into the station would, so I started in the sally port, came in through where they would come in through, like through the medical detector or through the area where they would be processed by the agent, you know, initially, and where they would go into a room.

So I observed all those areas. I did specifically ask to see where the food was prepared. I asked to see where cleaning supplies or janitorial supplies were kept, and I inspected those areas as well. So I asked to see medical, you

know, first-aid-type rooms. I observed those.

So I asked to see the general layout. Facilities that had showers, I looked at the showers, or facilities that had a designated room for an individual to use a shower wipe, I asked to see those areas as well.

Q. So would it be fair to say you basically inspected the entire station?

A. I inspected the entire station where an individual coming in -- most of the stations had other areas that agents and different people use. I didn't obviously look at those areas, but I looked at all the areas that were applicable to the individuals.

Q. So were you present in court yesterday when Roland Alexander testified about compliance evaluations?

A. Yes, I was.

Q. And what is your opinion of this compliance evaluation process?

A. I think the compliance evaluation process is -- I was actually impressed with it, and I was impressed with his testimony. Self-inspections are always, you know, a very good tool. They're a best practice. And I felt like he was very, you know, very adamant about his work and very, you know, on top of what he does, and I think that that's very important, that you have someone in a role that strongly believes in what they do.

And I thought that his testimony about the follow-through with the -- I believe he called them after-action reports, I thought that was very important, and the fact that he testified about documenting both, you know, when he found things that were compliant but when he also found things that were noncompliant, because the entire purpose of inspection, you know, self-inspections, is to find your internal problems.

If you're not inspecting to find what you're doing wrong, then, you know, if you just have someone that's saying, yep, we're doing this right, we're doing this right, we're doing this right, there's really -- I mean, no one's going to be doing anything right a hundred percent of the time. At least that's my opinion after having been in 25 years of the business I've been in. You know, it's -- I often say it's a very imperfect world. And, you know, I think that the self-inspections are an excellent tool.

Q. Are the compliance evaluations announced in advance?

A. He said they were not, and I have no reason to doubt that.

Q. He referred to them as no-notice evaluations, I believe. Is that --

A. Yeah, I gathered that they were unannounced or no-notice, yes.

Q. And is it more effective if the inspector does it unannounced?

A. Oh, absolutely.
Q. And why is that?
A. Oh, well, I mean, you obviously, I think, as Your Honor said the other day, you don't want to give people time to, you know, polish the floors ahead of your visit. So you know, it's always better if someone doesn't know that you're coming.
Q. And is it your understanding that the self-inspections are done by a Border Patrol agent who works in the station or by somebody outside?
A. There's room for both. You know, I think that the advantage to having -- you know, I mean, I guess you're asking about, when you say "outside," you mean someone still within Border Patrol but that doesn't work at that particular station?
Q. Yes.
A. Okay. Yes, I mean, the advantage to that is they understand the operation and the processes, but they don't necessarily have a vested interest in saying, yes, my facility is doing everything a hundred percent perfect.
MS. PARASCANDOLA: Ms. Kershaw, would you please show us Joint Exhibit 846.
Could you please scroll to the next page.
BY MS. PARASCANDOLA:
Q. Ms. Skipworth, do you recognize this document?
MS. PARASCANDOLA: And Ms. Kershaw, if you could

scroll down a few pages so she could have a look at it.

A. Well, it looks like a memo regarding one of the compliance evaluations.

MS. PARASCANDOLA: Ms. Kershaw, could you please scroll to page 5.

I'd like to ask plaintiffs' counsel to stop having a conversation behind me. It's quite distracting.

Thank you.

MR. LONDEN: We apologize for any distraction. We will not --

THE COURT: Well, you can do that. Just move away from the microphone, maybe.

MR. LONDEN: We won't have conversations.

THE COURT: All right.

MS. PARASCANDOLA: Ms. Kershaw, could you scroll up one page to page 4. Okay. Oh, I'm sorry. They're out of order. If you could scroll down a couple pages to the beginning of the checklist.

BY MS. PARASCANDOLA:

Q. Ms. Skipworth, do you recognize this checklist?

A. Yes. I recognize this as one of the compliance evaluation forms.

Q. Uh-huh. And in your opinion, is this adequate for evaluating compliance?

A. Well, I mean, I think that it's a good form for an

inspection form, if that's what you're asking. I mean, it's hard to -- I guess that's a little tricky question when you say "evaluating compliance."

Q. Of course. So let's go through the form.

So the first question is, you know, "Are the policies posted and visible and accessible for all agents to use?" You know, why is that important?

A. Well, you want the agents to have availability to the policy so that they're aware of and have access to make sure that they're following the policies and aware and know what, and so if there's any question about what they need to do, that they have access to the answer.

Q. Uh-huh. So let's go down to the area -- areas of this form that are within your expertise.

So item number three on the form asks or has checkboxes for such amenities as meals, drinking water, juice, baby formula, welfare checks, medical care, including the medical screening form, bedding and blankets, and other amenities.

Do you see that?

A. Yes, I do.

Q. Uh-huh. And why is it important to have I guess a paper form checklist that someone actually has to go in and fill out?

A. Well, it just provides a layer that someone has physically, and I believe this is saying that the e3DM logs

were checked for those particular items.

MS. PARASCANDOLA: Ms. Kershaw, would you scroll to the next page.

BY MS. PARASCANDOLA:

Q. And so question number five asks whether the fixtures I guess in the hold room comply with the standards and are functional, and why is it important to do this sort of inspection and to document it?

A. Well, you want someone to go in, of course, and make sure that the, you know, that the fixtures are functional, you know, that the professional cleaning and sanitizing is performed and logged, you know, all the things listed, you know, that the signage is indicating that the water is potable or potable.

So it's very important to have someone ensure that these things are in place.

Q. And so the items that are asked -- that the form asks the evaluator to check include toilet and sink, whether there is professional cleaning and sanitizing at least once per day, whether there are drinking fountains or clean drinking water, along with clean drinking cups.

Actually, I wanted to ask you, based on your site visits, did you observe that there were drinking fountains and clean drinking water provided separately in five-gallon containers?

A. Yes, I did observe that.

Q. Okay. And is it important to have signage indicating that that water is potable?
A. Yes. It is important.
Q. Uh-huh. And why is that?
A. Well, I think there's been confusion amongst individuals about whether or not that water was clean, and I think that just hopefully provides them some assurance that that is safe to drink, you know, to -- you know, everyone wants clean water, and anything that you can do to help someone understand that that water is safe to drink is just an added layer of, if nothing else, just understanding.

I did hear, you know, someone did -- the witness the other day said that in her country it's not safe to drink that water, and just letting her know, you know, beyond someone verbally saying, you know, that this water is safe to drink.

Q. And it says here that one of the items on the checklist is to make sure there is adequate temperature control and ventilation. Why is that important?
A. Well, of course temperature control and ventilation are important in any environment, and checking the temperature to make sure that it's within a comfortable range, comfortable range is something that is really hard to establish, I think that's already been established in some previous testimony, but checking the temperature to make sure that it is in within what could be determined in my area maybe called an acceptable

range. There are some ranges of those and -- but making sure that it's not, you know, really cold or really warm, making sure -- number one, just making sure that the ventilation system is working.

Q. And item six on the form asks, "Does your location have a process in place to ensure that juveniles are offered food and liquids at appropriate times?" And it refers to the TEDS standards.

And you know what the TEDS standards are; right?

A. Yes, I'm familiar with them.

Q. Okay. And so the evaluator checks four things, whether the process ensures that juveniles are fed upon arrival, whether they're provided water, milk and juice, and, importantly, unlimited access, snacks, unlimited access to that, and baby formula and toddler foods, and that they're properly stored and labeled.

Why is it important to document that?

A. Well, the question is asking, "Does your location have a process in place to ensure" -- well, I mean, it's vital that they ensure that the individuals meet the TEDS standards, that they're provided food and snacks and of course, you know, water and beverages, and the baby formula and toddler foods are properly stored and labeled.

Baby formula and toddler foods, those are critical in terms of -- I mean, the USDA requires that you not ever serve

anyone expired infant formula, and I did note that, when I was in all the stations, they've taken the practice of taking like a marker and putting -- they've done a best practice, it's not a requirement, but they actually label every item. They look at what the use-by or sell-by, or infant formula the expiration date, they take a marker, and they actually write it on, in big letters, they handwrite it on the front of the package, to help them with rotating the food items.

The agents at the facilities explained to me that, because of the flow of people, sometimes it's greater, sometimes it's lesser, and sometimes there's children, and sometimes there's not, that these items may actually expire because of they're not being used.

And so to assist with rotating that stock and making sure that they discard it when it does go out of date, that they've taken the step of putting that on the front of it so that they have this bigger visual reminder of, you know, okay, this expires, you know, 1 of '20 or January of '20, so when this January rolled around, they would know to discard that, and it would also help them as a reminder to, I need to, you know, order more or buy, you know, purchase more.

Q. So is this an additional check to ensure that people in custody are receiving fresh food or food that is not expired?

A. Yes, I believe it is, yes.

Q. Okay. And in your observations, did all of the stations

have this practice in place?

A. Yes, I observed it in all of them.

Q. And what would be other reasons to label the food prominently with the sell-by or expiration date?

A. Well, just to make sure that the -- so that if the -- one of the things I think is really important is to promote comfort and to make sure that the individuals provided the food also feel secure with the food. I mean, you know, you want to promote a sense of -- you don't want them to be concerned about whether or not this is something safe for them to eat.

There's been discussion about or testimony about an expired burrito and some discussion about the coding of the dating, and so by adding that on there, individuals may or may not be concerned, but at least, you know, you want people to feel safe with the food that they're provided, and when you give someone something that is expired, they don't have a sense of safety or security, and so, you know, to promote, you know, you don't want to serve the individuals expired foods. It does -- it's not good for the overall running of the facility or the morale of the facility.

Q. Ms. Skipworth, I won't go through the remainder of the form here because I know you've reviewed it. In your opinion, do you find this to be a very thorough and complete form and process for evaluating compliance?

A. Yes, I believe it's a -- I believe it's a good and thorough form, yes.

THE COURT: All right, counsel. That's probably a good place to stop now for a noon recess. So we'll be at recess until 1:15.

Ms. Skipworth, you'll be back on the stand, 1:15, so don't get lost.

All right. We'll be at recess.

(End of Day 5, Part 1.)

C E R T I F I C A T E

I, Erica R. McQuillen, Federal Official Realtime Reporter, in and for the United States District Court for the District of Arizona, do hereby certify that, pursuant to Section 753, Title 28, United States Code, the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 17th day of January, 2020.

s/Erica R. McQuillen
Erica R. McQuillen, RDR, CRR
Federal Official Court Reporter